

GRACE PROCEEDINGS

GEORGIA'S RESPONSE TO HEALTH DISPARITIES
BY ADDRESSING CULTURAL COMPETENCE AND EQUITY IN HEALTHCARE

April 28, 2004 • The Loudermilk Center • Atlanta, Georgia



Minority healthcare stakeholders throughout Georgia and the nation present ways to narrow the gap in health disparities.

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FOREWORD

Kristal L. Ammons, MPH

Office of Minority Health

If you, as a Georgia healthcare professional, stakeholder or advocate, have become increasingly frustrated by the gaping disparities in health care for minority populations and are ready to make a difference, this summary of proceedings from the recent GRACE (Georgia's Response to Health Disparities by Addressing Cultural Competence and Equity in Health Care) symposium is a vaulting point for taking action. GRACE is Georgia's response to the Institute of Medicine's (IOM's) report on health inequalities entitled, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. More than 200 healthcare professionals, stakeholders and advocates participated in the one-day symposium convened by the Georgia Office of Minority Health (OMH), held April 28, 2004, in Atlanta. The symposium's objectives were to engage stakeholders in dialogue on topics of health disparities and equity in health care; gain input about what cultural competence means for Georgia; and secure the commitment of leaders and stakeholders across the state to develop and implement a three-year strategic plan to resolve these issues.

The national focus on health disparities has centered on the data from the largest minority groups who have consistently demonstrated higher risk and poorer outcomes. In Georgia, like the nation, most of the data and the discussions focus on African-American/Black and Latino/Hispanic comparisons of health outcomes to majority populations. Although there have been some improvements in access to quality health care among minority populations, the gap has not narrowed over time. Minority populations are still at the lower end of adequate health care and acceptable standards of health, namely in cardiovascular disease (CVD) and diabetes – two leading causes of morbidity in African-American, Hispanic/Latino and other minority communities. GRACE focused on these two leading causes of morbidity and their disparate occurrence in minority populations. The symposium explored ways to create a more culturally competent healthcare system.

This report summarizes the GRACE proceedings which presented challenges and plausible solutions in cultural competence, workforce diversity and combating CVD and diabetes in Georgia. Among the areas of focus were: 1) combating unlawful discriminatory practices that may lead to disparities in health; 2) establishing cultural competence in our healthcare system; 3) fostering cultural competence through education, recruitment and retention; 4) addressing cultural competence policy issues, such as mandating cultural competence; 5) implementing flexible standards for diverse populations; 6) implementing cultural competence initiatives in Georgia; 7) administering health care to diverse populations; and 8) promoting appropriate lifestyles to prevent CVD and diabetes.

The IOM report provided a foundation for GRACE ~ both as background information on the disparity and unequal treatment issues facing minority populations and as a framework for providing recommendations. As may be expected, the challenges that Georgia's healthcare system faces mirror challenges nationwide. OMH will use the findings and recommendations from GRACE to develop and implement the three-year strategic plan to narrow the disparate healthcare between minority and majority populations in Georgia. The goal is to move the state's healthcare system from acknowledging its problems and providing recommendations to taking action that will positively impact the standard of care for minorities in Georgia.

Georgia's Response to Health Disparities by Addressing Cultural Competence and Equity in Health Care Symposium, held April 28, 2004 in Atlanta, brought together more than 150 healthcare professionals, advocates and stakeholders.

Keynote Address: Strategies for Reductions in Health Disparities in Georgia

The keynote speaker for the opening session of GRACE, James R. Gavin III, MD, PhD, president, Morehouse School of Medicine (MSM) in Atlanta, Georgia, focused on strategies to reduce health disparities in Georgia. He pointed out that Dr. Martin Luther King, Jr., in his Poor People's Movement, cited injustices in health care as the most shocking and inhumane of all forms of inequality and injustice. The following gives a synopsis of Dr. Gavin's findings on the subject.

Racial and ethnic disparities have both near- and long-term consequences. For example in 1993, patients age 65 and older were four times more likely to have an amputation of all or part of a limb rather than the less intrusive and less physically and economically costly coronary artery bypass graft surgery. The explanation for such occurrences may be found in the cultural context of disparity rather than the lack of accessibility to adequate care. Even in cases where insurance coverage and access do not create barriers, there are disparities.

So, if access is not the issue, what is? Other contributing factors may include 1) clinical appropriateness and need, 2) patient preference, 3) the way in which health plans and systems operate and 4) conscious or unconscious biases among practitioners. Sometimes data sets are looked at differently. For example, in the case of hypertension, because it is more common in African-Americans, stereotypical thinking and actual prejudice may affect a physician's approach to care for African-American patients causing the physician to under-treat patients with this condition.

Some health plans schedule Medicaid patients in inconvenient time slots, saving the best times for paying patients. Cultural and linguistic barriers, patient preferences, poor adherence to treatment plans and disparities in the clinical encounter all play a role in the cultural landscape of healthcare administration. The result is extremely high death rates among minority populations. CVD was the leading cause of death in the United States in 2000 among all populations, but the rate of occurrence was higher among African-Americans.

HIV/AIDS is the leading cause of death in African-American men age 35-44 years. African-American male death rates from cancers are twice that of white men. Lung and bronchial, colon and rectal cancers all disproportionately affect African-Americans. Also when compared to white Americans, infant mortality rates among African-Americans are twice as high and the death rate from heart disease is two times higher. Hispanics/Latinos are twice as likely to die from heart disease than white Americans.

Another disparity to consider is the lower numbers of people insured in minority populations. Emergency room care is more likely to be used for routine care by African-Americans, partially due to lack of insurance. The implication is that minorities are paying more for a poorer outcome. Hispanics/Latinos make up the largest group of uninsured Georgians at 20 percent, and African-Americans make up the second largest at 13 percent. These basically mirror national coverage statistics which show Hispanics/Latinos with a coverage rate of 32.4 percent and African-Americans with a rate of 20.2 percent.

*Keynote Address:
Health Disparities in the
State of Georgia: a Focus
on Strategies for Reductions
in this Population*

*Presenter:
James R. Gavin III, MD
PhD
President, Morehouse
School of Medicine,
Atlanta*

Addressing the Disparities

There are many areas of acknowledged health disparities, but the most devastating ones are cardiovascular, coronary disease, stroke, cancer, hypertension, asthma, kidney disease, diabetes, various connective tissue diseases, arthritis and obesity. From 1999 to 2001, significant strides were made in the health and well-being of African-Americans, but the disparity between minority and majority populations still exists. The IOM report finds that even when income and insurance coverage are the same as whites, minorities are still less likely to receive sufficient treatment for a variety of ailments. This finding should spur doctors to ask why these disparities continue and why we are still tolerating them. The IOM report makes the following recommendations:

Legal, Regulatory and Policy Interventions

- Avoid fragmentation of health plans along socio-economic lines.
- Strengthen the patient-provider relationships in publicly funded health plans.
- Increase proportion of under-represented U.S. racial and ethnic minorities among health professionals.
- Apply same managed care protections of the privately funded plans to publicly funded plans.
- Provide more resources to enforce health laws.

“Life is filled with golden opportunities that are carefully disguised as irresolvable problems.”

*David Satcher
as Former US Secretary of
Health, Education and Welfare*

Health Systems Interventions

- Promote consistency and equity of care through evidence-based guidelines.
- Structure payment systems to ensure adequate supply of services to people who are at the highest risk.
- Provide incentives to help promote the elimination of disparities.
- Support the use of interpretation services.
- Support the use of community health workers.
- Develop preventive health teams.

Education

- Provide patient education programs.
- Provide cross-cultural education.

Knowledge is key. Action is power. The IOM definition of optimal primary care includes an understanding of the cultural, nutritional and belief systems of patients within communities that may assist or hinder effective healthcare delivery. Healthcare professionals have to understand the people for whom clinical decisions are made. “What do they eat?” Becomes an important question when you consider that for the worst diseases of our time, including CVD and diabetes, the first two recommendations are diet and exercise.

If the healthcare community is to galvanize support to decrease disparities, stakeholders must emphasize the implications, primarily economic, for all U.S. populations. The business case is compelling. For example: \$130 billion is spent annually treating diabetes, \$120 billion is spent on treating obesity and \$40.5 billion is spent on the treatment of end-stage renal disease.

The burden to research the causes of disparity and their implications on minorities, and to develop solutions falls largely on the shoulders of academia. Additionally, outreach programs must be developed and academia must work closely with the private and public sector to realize positive outcomes.

Settings for Action

- Families and Communities
- Schools
- Work sites
- Health Care Industry
- Media and Communications Industry
- Institutions, such as MSM's Center for Primary Care

Points of Attack

- Access
- Quality of care
- Lifestyle enhancement (making better choices)
- Quality of environment
- Balanced research agenda

Use Federal Support

- Department of Health and Human Services Initiative to Eliminate Disparities
- National Institute of Health Strategic Research Plan to Eliminate Disparities
- Healthy People 2010 Plan
- 100 percent Access, Zero Disparities Initiative
- The National Library of Medicine Strategic Plan

Community Action

- Hispanic Health Care Outreach Initiatives
- Northwest Georgia Partnerships
- Men's Health (100 Black Men)

The Morehouse School of Medicine's National Center for Primary Care recommends a three-dimensional approach to addressing health disparities and maintaining the assault, which involves:

- robust research,
- strong training programs,
- strong community outreach,
- more Centers of Excellence, and
- developing and monitoring new strategies to avoid approaches that do not work.

"We have a quality problem... Consider if some of the cars coming off the line at GM had three tires, some had four and some had five... We would say, immediately, that was a manufacturing process out of control. Well our healthcare system is consistently producing disparate results that show a process out of control."

*-Dr. George Rust, MSM
National Center for Primary Care*

Laying the Foundation for Addressing Racial and Ethnic Disparities in Georgia

The opening plenary of GRACE laid the foundation necessary to understand the concepts of cultural competence and how discrimination and racism play crucial roles in explaining health status and health disparities. Presenters shared their views on the status of diversity and cultural competence in Georgia's healthcare workforce and clarified where the state stands nationally. Existing CVD and diabetes health disparities in Georgia were examined as well.

Cultural Competence

Rocio Del Milagro Woody, LMSW

President/Founder, The Road to Recovery, Inc., Atlanta

One of the more significant trends in Georgia's cultural landscape is in the growth of the Hispanic/Latino community. From 1990 to 2001, the Hispanic population in Georgia increased by 300 percent. The state has the 11th highest Hispanic population in the nation, with 63 percent originating from Mexico. Most people who are categorized as Hispanic or Latino would not identify themselves as such. It is essential, then, that care providers familiarize themselves with the ethnic origin and culture of their patients, commonly identified as Hispanic/Latino, and note that, among other idiosyncrasies, not all of them speak Spanish.

To gain a better understanding, one might begin with a geographic orientation. Woody explained that patients of Mexican/American, American/Mexican (Ponchos) and Mexican/Mexican (Chicanos) are from the North American region. Hispanic/Latino Central Americans originate from the Honduras, Nicaragua, Costa Rica, Guatemala and El Salvador. Hispanic/Latino South Americans originate from Columbia, Venezuela, Ecuador, Peru, Argentina, Chile, Uruguay, Bolivia and Brazil. Patients of Puerto Rican, Cuban and Dominican Republican descent originate from the Caribbean. And, Spanish patients originate from the continent of Europe.

Primary Challenges in Hispanic/Latino Community

In her work in the field of mental health, Woody found that Latinos primarily suffer from alcoholism, illicit drug use, domestic abuse and depression (suffered by women two-times more than men). Several challenges in the healthcare system impede progress in addressing these and other health issues in the Hispanic/Latino population. These challenges include:

Language Barriers

- Initial contact with Hispanic/Latino patients (Patients speak various dialects. Learning Spanish will not solve the problem.)
- Patients may not respond well to interpreters.
- Translated materials/information from English to Spanish are not always accurate or culturally competent.
- Numerous patients will not respond to answering machines or services.

Opening Plenary:
*Laying the Foundation for
Addressing Racial and Ethnic
Disparities in Georgia*

Presenters:

*Rocio Del Milagro Woody,
LMSW
President/Founder, The Road
To Recovery, Inc., Atlanta*

*George Rust, MD, MPH
MSM National Center for
Primary Care, Atlanta*

*Carol Snype Crawford, MSW
Public Health Consultant, Atlanta*

Affordability

- Only 26 percent of the Hispanic/Latino population has private insurance.
- Workers see employer-sponsored and individual insurance as an additional expense.
- 27 percent use Medicaid, 7 percent use Medicare.
- 60 percent of the population is uninsured.
- The emergency room is used for primary care.

Accessibility

- Lack of private transportation
- Physical limitations to public transportation
- Lack of childcare
- Fear of enrollment in government programs, due to immigration status

Work toward a solution to the problem of cultural competence can begin by addressing these primary and other problems that face the fastest growing minority population in the state of Georgia.

Workforce Diversity

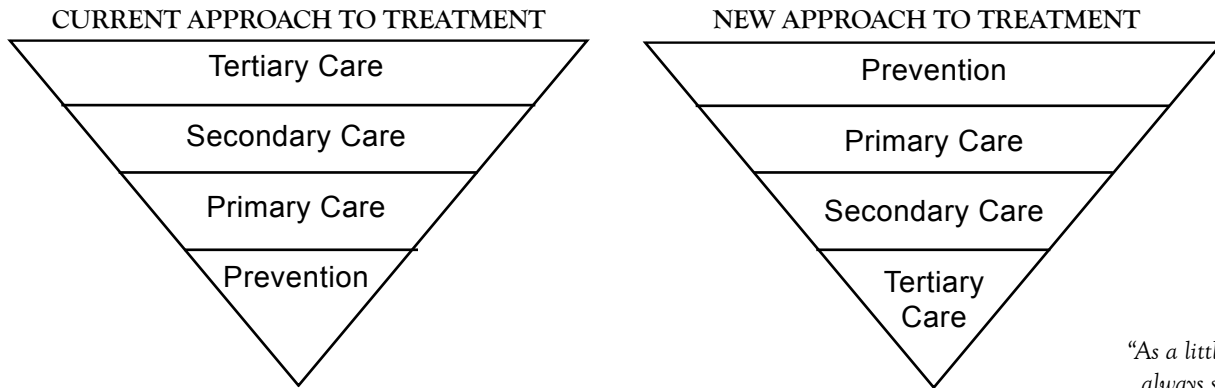
George Rust, MD, MPH

MSM National Center for Primary Care, Atlanta

In addressing the issue and challenges surrounding workforce diversity, Dr. George Rust of the MSM National Center for Primary Care shared anecdotes of his own experiences in working with people from diverse cultures. He asserted that currently, healthcare professionals tend to define culture in terms of race, ethnicity, national origin, geographic region, history and religion. We must begin to see culture as something that is developed or expressed over time, he says. For example, two people of the same race and ethnicity may be shaped by different cultural experiences – events that have happened in their lives over time. Differences such as gender, diverse experiences and backgrounds, such as social status, family dynamics and marriage, may cause people of the same race and ethnicity to express culture quite differently.

Dr. Rust recommended six things that we must do in Georgia to maintain a healthy diverse workforce:

- 1) Stop treating diversity like a problem, rather as a lover to be embraced.
- 2) Eliminate disparities. Realize that our healthcare system is designed to produce disparity in areas such as infant mortality. The negative outcomes are excessive costs and needless suffering.
- 3) Create a culturally competent workforce.
- 4) Provide training such as CRASH (Culture, Respect, Assess/Affirm, Sensitivity/Self-Awareness, Humility) courses in cultural competency to health professionals. In addressing cultural competence, we must still deal with racism, because it still exists. In the words of Wynton Marsalis, “Race is the elephant sitting in America’s living room.”
- 5) Create a proportionately diverse workforce. We cannot stop at the academic setting. We must spread the power and control throughout health organizations to create a diverse workforce.
- 6) Turn the healthcare system aright.



State of CVD and Diabetes in Georgia

Carol Snype Crawford, MSW
Public Health Consultant, Atlanta

To develop ways to combat the disparate presence of CVD and diabetes in minority communities, Public Health Consultant Carol Snype Crawford suggests that we must first determine what the causes are and what this phenomenon means for Georgia. CVD is the leading cause of death in America, and Georgia is no exception. There are several characteristics that increase one's risk of coronary heart disease, stroke and diabetes. These characteristics are more prevalent in the minority population than in the majority population. We also see a greater impact of these diseases among minorities. We see opportunities in what is recommended to address these differences, such as in the Healthy People 2010 Standards for the nation.

The CVD rate in Georgia has declined some over the past two decades, but it is alarming that the rate of decline has slowed in recent years. Also notable is the tie between the lowest-income counties and the high rates of CVD and diabetes that exist in these communities. Moreover, from 1999 to 2004, black males suffered from these diseases at a much higher rate than their white counterparts. And, interestingly, 62 percent of black males affected by stroke could not identify a symptom of stroke.

Cardiovascular Disease

CVD includes all diseases of the heart and blood vessels, including ischemic heart disease, stroke, congestive heart failure, hypertensive disease and arteriosclerosis. When we look at how Georgia compares nationally, as reported in the Georgia Department of Human Resources Division of Public Health's 2004 Georgia Highlights: Heart Disease and Stroke, 36 percent of the deaths in Georgia are from CVD, and Georgia's CVD death rate is 11 percent higher than the national rate. There is not enough accumulated data on other minority population groups, but the rates for African-Americans are representative of the disparities that exist. When we consider gender within Georgia, we find black females die from CVD at a rate 26 percent higher than white females. Black males die from CVD at a rate 23 percent higher than white males. By age, in 1999, 22 percent of all CVD deaths were among persons less than 64 years of age; 42 percent who were less than 65 years old were black males compared to 26 percent who were white males.

These differences may be attributed to such factors as poverty. When we look at counties where 50 percent of the population has income 200 percent below the national poverty level, there is overlap between the disease impact areas. There is also some overlap between the disease population areas in counties where 50 percent or more of the communities' residents are African-American.

"As a little girl, I was taught to always say grace before meals. It was a blessing for the food we were about to receive for the nourishment of our bodies, not for the expansion of our bodies... Let's say grace in Georgia, so that all may say Amen, meaning so be it. It is now well with us."

-Carol Snype Crawford, MSW
Public Health Consultant

Diabetes

Diabetes is twice as common among African-Americans in Georgia than in the white population. Death rates from diabetes are rising 1.8 percent a year in Georgia. For every two people who know they have diabetes there is one who is unaware they have the disease. Complications from the disease are staggering. There is a link between diabetes and CVD. They share common risk factors. Almost every minority has a personal story to tell about someone they know who is affected by the disease. We know that the impact is at near crisis, when considering the number of amputations and disparate occurrence of renal failure in the African-American community. Obesity is one of the root causes of diabetes; 900,000 people in Georgia are overweight; 63 percent are 30 pounds overweight; and about 12 percent of deaths in the U.S. are attributed to lack of physical activity. Knowing the integration and the relationship of obesity and diabetes, it is imperative that we get to the reality of addressing the differences in impact on people's lives.

A snapshot of the seriousness of the disease in our state is captured in the 2002 document *The Burden of Diabetes in Georgia* from the Georgia Diabetes Advisory Council. According to August 2002 statistics from the Georgia DHR Division of Public Health Chronic Disease, Injury, and Environmental Epidemiology Section, black males are twice as likely to die from diabetes than their white counterparts and black females are three times more likely to die from the disease. While we've made tremendous progress in Georgia, we are still considerably shy of the Healthy People 2010 goals for the nation. We have a tremendous opportunity through the consensus work from GRACE to develop strategies that will collectively take the work that stakeholders are doing individually and have a plan that will drive these rates down in Georgia.

Session I-A:

Health Disparities: Civil Rights Perspectives, Strategies and Approaches

*Session I-A
Health Disparities: Civil
Rights Perspectives, Strategies
And Approaches*

Mission and Purpose of the Office of Civil Rights (OCR)

Roosevelt Freeman, JD

Regional Manager, Office for Civil Rights, Reg.-IV, Atlanta

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OCR is responsible for ensuring that institutions, which are recipients of federal funding through the Department of Health and Human Services, do not discriminate against program beneficiaries on account of race, color, national origin, disability, and in some instances, age and sex. OCR has authority over health plans, health clearinghouses and certain healthcare providers concerning enforcement of the federal standards for privacy of individually identifiable health information ("the Privacy Rule"). This authority relates in part to unauthorized disclosures of one's personal health/medical information.

Overview of Title VI of the Civil Rights Act of 1964

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color or national origin in programs receiving federal financial assistance, such as Medicare, Medicaid, NIH Grants and Public Health Services Grants and Awards. Title VI protects persons of every race, color or national origin. Recipients may not: deny an individual a service, aid or other benefit; provide a benefit, which is different or provided in a different manner; subject an individual to segregation or separate treatment; restrict an individual in the enjoyment of benefits, privileges, etc.; treat an individual differently in determining eligibility; or deny a person opportunity to participate on a planning board.

Title VI also requires compliance standards, which are key tools in OCR's enforcement efforts focusing on health disparities. Recipients of federal financial assistance may not use any criteria or methods of administration to defeat or impair the accomplishment of a child health services and primary program's objectives or select sites or locations of facilities that will exclude protected individuals. Block grants ensure community services; preventative health and health services appropriate to race, age and disability; alcohol abuse, drug abuse and mental health services; maternal and child health services and primary care.

"Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, creed and national origin in all programs or activities that receive federal Financial assistance".

What is Discrimination?

Discrimination can occur in the form of disparate treatment either intentional (overt) or unintentional (inferred unjustified adverse conduct). Actions that have a disparate impact causing disproportionate adverse effects are considered discrimination as well. Health disparities, in general, relate to the disproportionate differences in health outcomes among racial and ethnic populations; inequities in access to, and/or, ineffective utilization of available medical care, treatments and research, etc; or disproportionate affliction rates for various medical conditions/disease categories. Health disparities are caused by a variety of factors, including socio-economic, cultural/lifestyle, environmental, hereditary, geography, health, risky behaviors, reluctance to seek timely medical attention and discrimination.

Disparities from a Civil Rights Perspective

Statistics, studies and compliance efforts in the Office of Civil Rights are showing that discrimination – including stereotypes and biases – is a contributing factor in health disparities. When we talk about discrimination, the key is determining differential treatment. That is, in any given case, everyone was similarly situated but someone was treated differently from the others because of race or other discriminatory reasons. Discrimination occurs when a person or group of persons is subjected to different, unequal/adverse treatment because of their race, age or on some other unjustified prohibited ground.

The challenge in the medical setting is that most people do not know when they've been discriminated against. As minorities become more educated about what their choices are and what appropriate treatment should be, they can better recognize when they've become a victim of discrimination. Healthcare stakeholders must begin to help minority populations become more aware of how the doctor speaks to them, what information he gives them and whether patient referrals are given when appropriate. Inappropriate action in any of these areas can contribute to health disparities.

Civil rights violations in health care must be addressed collectively, since discriminatory practices can cause disparities in the prevalence of certain diseases. For example, prostate cancer is a preventable disease if detected early enough. Some of the disparity is due to personal choice. However, failure to routinely administer all examinations (i.e. blood tests, digital exams, etc.) to African-American men, for instance, could be considered discriminatory.

Diabetes is another classic example. Even with access to insurance and treatment, there are still discriminatory practices that account for differences in the number of African-Americans who receive surgeries that could prevent advanced stages of the disease, like their white counterparts. Whites are almost three times more likely than blacks to receive re-vascular procedures to save limbs. Nationwide, African-American diabetics are 50 percent more likely to receive an amputation following admission to a hospital for a related condition.

Advances in Addressing Limited English Proficiency (LEP)

Marshall Tobias

Office for Civil Rights, Reg.-IV, U.S. Department of Health and Human Service, Atlanta

The OCR addresses discrimination due to ancestry/ethnicity/place of birth, immigration status, citizenship status, lack of social security numbers and language barriers. The latter, limited English proficiency (LEP), is fast becoming a major contributing factor to health disparities in Georgia and throughout the nation. There are over 300,000 households in Georgia that are linguistically isolated – households with family members over 14 years old who have trouble speaking English. Title VI of the Civil Rights Act of 1964 requires providers who receive funding from the US Department of Health and Human Services (HHS) to take reasonable steps to ensure that the person who has LEP has meaningful access to their programs through interpretive services. However, the requirement does not specify how to provide the service, and therefore, providers must themselves find solutions to the language barrier problem.

When cost is a challenge for a single, private provider, the OCR may recommend sharing an interpreter via phone lines that allow the provider and patient to communicate through an interpreter from a neighboring healthcare facility. However, this approach would not work in a hospital emergency setting. For example, if a woman enters a hospital ready to deliver a baby an interpreter would need to be at that location and competent to communicate the patient's medical needs. Large hospitals sometimes employ people from all over the world, but it is unrealistic to expect a healthcare professional who speaks a patient's language to come back to the hospital on a day off to provide interpretive services. The facility must identify several employees who are available and competent to serve.

The Office for Civil Rights assists providers in finding solutions to LEP by offering the following guidelines for establishing acceptable standards of service.

Step I: Determine what your obligation is by contacting the OCR for assistance. Revised guidelines for appropriate measures in providing equal access to services were published in August 2003.

Step II: Determine how often LEP patients come for care. If your practice or organization is language-friendly that number will increase.

Step III: Determine what service you can provide. A hospital, which offers in-patient, out-patient, and emergency care, must provide services to patients with LEP in all situations that have an impact on their health and well being.

Step IV: Determine your resources – personnel and physical. Is there a bi-lingual person on staff who can be trained to provide interpretive services? Are they confident and prepared to take on the responsibility of providing services to patients with LEP? Physical resources may include phone lines with splitters allowing for three-way conversation with patient, provider and interpreter. Community resources may be available, such as the Medical Interpreters of Georgia, which maintains a database of interpreters.

Session Recommendations and Additional Considerations

Tobias and Freeman, in dialogue with session participants, shared the following recommendations and considerations.

- The ability to communicate or interpret effectively must be good or it can have an adverse affect on health disparities.
- The state of Washington has the only certification program for interpreters. Federal and state governments do not require interpreters to become licensed. However, they must be tested for competency.
- Bilingualism does not constitute a qualified interpreter. Additional training may be necessary.
- Diversifying our healthcare system so that it employs more people who speak different languages is one approach to addressing LEP.
- The OCR would never attempt to require providers to have an individual interpreter for each different language and culture represented in a community. The approach is rather to streamline and have as much impact as possible. Otherwise, costs could sink the entire ship.

Session I-B: Establishing a Culturally Competent Healthcare System

*Peter Doliber, Director
Community Benefits, Memorial Health University Medical, Savannah, GA*

Culture is something that starts internally and then grows to become external. The only way to affect cultural change is to look within before you look on the outside. Along with Mercer University, Memorial Health University Medical in Savannah, Georgia, is a teaching facility, yet it does not conduct training in cultural competency. It is an urban hospital surrounded by a rural community, 50 percent black and 50 percent white. A majority of the African-Americans seeking care at Memorial Health are low-income.

As facilities and other providers like Memorial Health move toward understanding cultural competence, they must make sure it is about understanding rather than about difference; that it's about reaching out, rather than putting up barriers; and that it's about sensitivity rather than about complication and slowing down the medical practice. We have the power and the ability to effectively address the challenge of cultural competency.

It is important to start at the end – to ask the question, “Where do we want to end up?” America traditionally is considered to be a melting pot, but it is more like a tossed salad. To have a melting pot, you must melt all the ingredients down until you have one thing; but a tossed salad has several distinct pieces. Fortunately, in America, we are all distinct beings with different backgrounds and everyone’s culture is unique and specific and pertains to their own situation. We have to have a respect for every distinct being. It is incumbent upon health service providers to first understand their individual cultures – perform a self-assessment. Then, they can begin to understand the community they serve and the different cultures of the individuals they serve.

Session I-B:
Establishing a Culturally
Competent Healthcare System

Presenters:

Peter Doliber,
Director, Community Benefits
Memorial Health University
Medical, Savannah, GA

Ralph Austin, MD
Vice Chairman, GA Board
For the Physician Workforce,
Macon, GA

Tary Brown, CEO
Albany Area Primary
Health Care, Inc. Albany, GA

Approaches to Achieving Cultural Competence

Three things must be understood in order to establish cultural competence.

1) First understand the culture within. Your institution – the provider culture, the doctor’s office, hospital, etc., – generally reflects the culture of the people who work there. That’s usually the first stumbling block, because leadership will develop ways to excite, motivate and cheer lead the people who work for them, rather than consider teaching respect and sensitivity for one another and the people they serve.

We can throw around all the themes like teamwork and team player and Who Moved My Cheese?, but if we do not have a culture internally that responds and works back and forth, those tools won’t work. To address the culture within, we must consider what our healthcare facilities are doing when phenomena occur such as when like races and ethnicities eat lunch with each other everyday in the cafeteria rather than mixing with people who are different from themselves. We must consider what is at the root of staff not leaving that comfort zone amongst themselves before we expect them to be comfortable with reaching out to patients of different race and ethnicity.

2) The community itself has a culture based upon its history and the people who live there. You have to understand the culture of your community, which is ever changing, or you can’t address the culture within your institution or, most importantly, that of the people you serve.

3) You have to understand the culture of the individual. While there are a lot of similarities in one race or ethnic group of people, each person is different. Each individual has a culture.

At some point, all three intersect. When you can overlay what happens internally, externally and in the individual, that’s when you have cultural competency. The pieces that lead to that are education, understanding how different cultures operate and empowering people to speak. It may be a physician who looks like you. It may not be. It’s about trust. Trust comes from experiences shared and listening.

One of the problems we face is physicians, specifically, are taught to diagnose a problem and solve it. They are not taught to listen. If we’re going to have success, we have to teach people how to listen. It’s the physician being able to say, maybe I’m not the right person to hear and understand what the patient needs. That’s where respect comes in; it’s a two-way street. We have to teach patients that they have a right and a responsibility to speak up and say they don’t understand. If it’s true that disparities exist even when all other conditions are equal, it does boil down to person-to-person connection. It’s beyond health status or even where you live. It’s a compound problem with compound solutions.

In part, the change has to come from those who understand the importance of cultural competence. We have to appeal to the values that the providers and the patients possess. For example, in one case scenario, a clinic was formed after assessing the health needs of a community. But when the facility was complete, one woman remarked on the beauty of the building. Then she asked if someone could fix the light at the end of the street. There was a crack house there, and otherwise she would be afraid to come to the facility at night for treatment. We were looking at the indices of the disease and the patients were looking at safety.

Consider what hospitals value most. You're going to the hospital saying you really need to be teaching cultural competence. If you can help the administration save money by making thousands of patients healthier and their hospital stays shorter by talking to them about non-emergent issues in the emergency room, then you appeal to what the administration values.

At the nexus is the individual patient's well being. A person's well being is directly connected to his socio-economic status. That status determines what insurance he has and how he's going to pay for care, which affects access to care. If we as a nation, state, county, city, individual, work with the patient at the nexus – at all of these points along the way – we can affect his well-being and begin to spiral up instead of spiral down. This will only happen by understanding the culture in which we have to work.

A Cultural Competence Model: AAPHC, Inc.

Tary Brown, CEO

Albany Area Primary Care, Inc., Albany, GA

Albany Area Primary Health Care, Inc. (AAPHC) in Albany, Georgia, consists of Baker County Primary Health Care Center, East Albany Medical Center, East Albany Pediatrics and Adolescent Center, Edison Medical Center, Dawson Medical Center, Lee Medical Arts Center and the Rural HIV Model. The system has been recognized nationally for its strides in cultural competence and meeting the healthcare needs of the diverse populations in its community. AAPHC is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Still, AAPHC's chief administrator, Tary Brown, says it is not culturally competent and has not done a good job of eliminating health disparities. The system, however, has not turned a blind eye to these issues. Achieving success is an ongoing process that changes day to day as the needs of the community change.

The community of Southwest Georgia changes from county to county. Ethnically, one county is 80 percent African-American and 20 percent white. Another is 85 percent white and 15 percent African-American. As a community health center, AAPHC looks at four "A's": availability of services; affordability (what method of payment, whether there will be a sliding pay scale, etc); accessibility (Some counties, such as Newton, have myriad healthcare services in close proximity to one another. Other counties are more disjointed.); and acceptability (Patient surveys are conducted and analyzed to determine whether the system is meeting patients needs.).

Cultural diversity is different for each county served by AAPHC and the system must be aware of and manage key differences. Skills, particularly, communication skills, must be developed in order to work effectively with the different populations represented to get the message across. The system continues to ask its patients/consumers if they are meeting their needs. Services are provided to 25,000 individuals and 100,000 patient visits are managed.

Albany has the largest HIV program in the United States outside of major metropolitan areas like Atlanta. Around 1982 AAPHC began to see HIV/AIDS in its patient population. Around 1990 there were 90 patients who were HIV positive. Surveys were conducted and a grant was written to fund services targeted to gay, white males. Service was driven by staff with a personal interest in the health challenges of this particular patient population.

A few years later, the demographics of the patient population with HIV/AIDS began to change. Now 85 percent are African-American, 42 percent are females. Patients have contracted the disease from drug abuse, heterosexual contact and bi-sexual intercourse.

Staff and program services have changed as time has passed. In one instance AAPHC found that women were not getting pap smears, flu shots and pneumonia shots because they thought they contracted the disease the last time a doctor stuck them with a needle. AAPHC has to listen and be open to such thinking of patients. People must be hired who are non-judgmental and who have a particular interest in HIV/AIDS. The reasons why a potential hire wants to work in a particular area is weighed evenly with credentials. Currently, some hires include a mid-level physician's assistant who is a minority with a social work degree, an African-American nurse with religious ties and a family member with HIV/AIDS and a white medical doctor with his own health problems who understands disabilities.

AAPHC attempts to identify staff that can relate to the patients so that their medical needs can be addressed effectively. Programs have been developed that address the consumers' needs beyond health status that nevertheless, can have an effect on health, such as housing, dental care and nutrition. Rather than rely on vital statistics, AAPHC surveys the target population faced with the health problems they are trying to address and identifies services that not only it can offer but that can be coordinated through other agencies – so as not to duplicate services.

Although AAPHC does not consider itself to be a culturally competent healthcare system, it does consider itself to be better than most, with a long way to go. AAPHC is making progress toward managing individuals to provide services to the community that wants to access its services. Administrators measure their success by the increased numbers of patients they serve and how they react to the service they receive. Administrators believe AAPHC's JCAHO accreditation means nothing if the patients it serves are not content with the services they're providing.

Establishing a Culturally Competent Workforce from a Provider's Perspective

Ralph Austin, MD

Vice Chairman, GA Board for the Physician Workforce, Macon, GA

The Georgia Board for the Physician Workforce is a group of people selected by the governor to administer \$38.5 million to Georgia's medical schools and residency programs. Initially each school – Emory and Mercer universities, Morehouse School of Medicine and the Medical College of Georgia – had a formula of deliverables under Governor Roy Barnes' administration. Medical schools had to retain 50 percent of its students in Georgia and 50 percent of students completing residency programs had to become primary care physicians. As a result, there is now a deficit in physicians who specialize.

Another major task for the Board is information acquisition regarding the state's workforce needs. New figures show that there are marked shortages in pediatricians and cardiovascular physicians. There also is a deficit in the number of minority physicians in Georgia. The physician workforce currently is 77.4 percent white, 11.9 percent African-American, 7.7 percent Asian, 3 percent other and less than 1 percent Hispanic. Georgia also relies heavily on physician migration from other states and on international medical students.

The latest fact sheets on physicians training programs reveal that Georgia ranks 34th among the 50 states that have residency programs. This ranking reflects the number of residents per 100,000 people in the state. Historically Georgia has been consistent in its attempt to bridge this gap, over 50 percent of the graduates from our residency programs have stayed in Georgia to practice medicine. This increases to 70 percent for family practice graduates.

Unfortunately, the trend over the past three years has been to cut funds from all of the residency program and medical school budgets. Many schools are in danger of damage to critical infrastructure if these cuts continue. Amidst all of these challenges, however, Georgia still has a responsibility to make its institutions responsible for training much-needed culturally sensitive physicians.

As a workforce, the key is educating and developing physicians who are adept at asking their patients what they heard them say. Acquiring information is most important, whether it be from the patient or a family member. This is a major challenge in Macon, GA, for example, where the population is predominantly African-American, but the physician workforce is not. Meanwhile, physicians working in the urban and rural areas of Georgia are in deep crisis due to the economy, escalating malpractice insurance costs and the growth of the uninsured population. All of these factors disproportionately burden minority physicians.

While it addresses challenges to Georgia's medical training grounds and physician workforce, the Board wants to join the cultural competence conversation and is seeking input from healthcare stakeholders to help chart its path in this arena.

Session Recommendations

- You must live and love your mission statement or leave it.
- Providers have to brace and strive for cultural competence, not buckle under the pressures to work fast.
- Providers have to, first, care about the people they serve.
- We have to tie cultural competence to accreditation and to licensure of physicians and say you will not be accredited or receive your license if you do not comply. Until physicians understand they will not be able to practice their profession unless they submit to these paradigms, we will not see the change we really need.
- Cultural competence is a quality initiative, but policy changes that have stuck are those tied to regulation, law and reimbursement. The only way to effect permanent change is to incorporate cultural competence – define it and develop outcome measures – in regulations for accreditation and reimbursement.
- Tying cultural competence to accreditation may work for hospitals, but doctor groups like AAPHC can't afford it and don't have to have accreditation. So, it would not be an effective approach for them.
- We need a resolution to come from GRACE saying that we no longer want lip service by the health system regarding cultural competence, but we want to see some changes and we want to see them now.
- We can bring pressure on institutions to make cultural competence a deliverable by the institutions.
- African-American physicians need to be encouraged to specialize in transplantation, because the large numbers of African-American patients in need of care is disproportionate to the number of African-American providers. Currently, there are only 18 African-American heart transplant surgeons in the country and only one African-American director of a heart transplant program.

"We, in our society, believe that every criminal has a right to a lawyer, yet we are one of only two nations- the United States and South Africa- that does not believe every sick person should have a right to a doctor."

*-Ralph Austin, MD, quoting
Joycelyn Elders, MD,
former U.S.
Surgeon General*

- Cultural competence can occur across racial lines. You do not have to be an African-American provider to be culturally sensitive to African-American patients.
- Georgia is one of few states where Medicare does not cover heart transplants through Medicare. Steps should be taken to provide such coverage.
- Focus on legislators and let them know that Georgia does not help African Americans and other minorities get the cardiovascular care they need.
- Medicaid hardly pays primary care physicians for the care they are giving, and this adversely affects physicians who serve poor and minority populations who use Medicare and Medicaid. The federal government needs to do a better job in cardiovascular care coverage and all areas across the board.

Session I-C:
*Fostering Culturally Competent
Care Through Education,
Recruitment and Retention*

Presenters:

Joseph Hobbs, MD
*Vice Dean, Primary Care and
Community Affairs, Medical
College of Georgia, Augusta, GA*

Raymond Otis, MD
*Office of Rural Health Services
Advisory Council,
Camilla, GA*

Session I-C:
*Fostering Cultural Competence Through Education, Retention and
Recruitment*

Joseph Hobbs, MD

*Vice Dean, Primary Care and Community Affairs, Medical College of Georgia,
Augusta, GA*

Dr. Joseph Hobbs is responsible for providing Medical College of Georgia students with a foundation in primary care as well as interfacing students with the communities in which they will serve. Fostering cultural competence in the 180 graduates, on average, presents a unique challenge in that cultural competence is not offered as a course that has the same sort of gravity that biochemistry, anatomy, pharmacology or other subjects have. It is usually embedded within other basic science and clinical courses. In the rigid and regulated educational system, changing this approach is a daunting task. However, it is a challenge worth addressing if medical schools are to produce practitioners who can effectively interface with diverse communities.

Findings from The National Academy of Sciences (NAS)

So, how can the educational system address the greater good of graduating practitioners who have the necessary cultural competencies to provide healthcare services? Before analyzing ways to foster cultural competence in education, it is important to first consider the challenge in a broader context. What follows is Dr. Hobbs' synopsis of the findings and recommendations presented in The National Academy of Sciences' 2002 study on unequal treatment.

- Racial and ethnic disparities in healthcare exist and, because they are associated with worse medical outcomes in many cases, are unacceptable.
- Racial and ethnic disparities in healthcare occur in the context of broader historic and contemporary social and economic inequality, and persistent racial and ethnic discrimination is evident in many sectors of American life.
- Many sources (including health systems, healthcare providers, patients, and utilization managers) may contribute to racial and ethnic disparities in healthcare.
- Bias, stereotyping, prejudice and clinical uncertainty on the part of healthcare providers may contribute to racial and ethnic disparities in healthcare.
- A small number of studies suggest that racial and ethnic minority patients are more likely than white patients to refuse treatment.

Recommendations from The NAS

General

- Increase public and key stakeholders' awareness of racial and ethnic healthcare disparities.
- Increase healthcare providers' awareness of racial and ethnic disparities.

Legal, Regulatory and Policy Interventions

- Increase the proportion of underrepresented U.S. racial and ethnic minorities among health professionals.
- Apply the same managed care protections to publicly funded HMO enrollees that are applied to private HMO enrollees.
- Provide greater resources to the U.S. Department of Health and Human Services (DHHS) Office for Civil Rights to enforce civil rights laws.

Health Systems Interventions

- Enhance patient-provider communication and trust by providing financial incentives for practices that reduce barriers and encourage evidence-based practice.
- Support the use of interpretation services where community need exists.
- Support the use of community health workers.
- Implement multidisciplinary treatment and preventive care teams.

Patient Education and Empowerment

- Implement patient education programs to increase patients' knowledge of how to best access care and participate in treatment decisions.

Cross-Cultural Education in the Health Profession

- Integrate cross-cultural education into the training of all current and future health professionals.

Data Collection and Monitoring

- Collect and report data on healthcare access and utilization by patients' race, ethnicity, socioeconomic status and, where possible, by primary language.
- Include measures of racial and ethnic disparities in performance measurement.
- Monitor progress toward the elimination of healthcare disparities.
- Report racial and ethnic data by federally defined categories, but use subpopulation groups where possible.

Research

- Conduct further research to identify sources of racial and ethnic disparities and assess promising intervention strategies.
- Conduct research on ethical issues and other barriers to eliminating disparities.

Road Map to Fostering Cultural Competence in Education

While the NAS study makes recommendations, it does not map out how to take action. Dr. Hobbs attempted to bridge that gap by offering several solutions to the challenges of incorporating cultural competence in education.

- 1) Eliminate barriers to culturally competent clinical education by addressing the following:
 - Student attitudes and biases
 - Faculty attitudes and biases
 - Attitudes of adult learners
 - Non-inclusion of cultural competency as a part of overall educational mission
 - Ineffective clinical educational venues for cultural competency education
- 2) Address the following intrinsic educational considerations:
 - Age, gender, ethnic and socioeconomic distribution
 - Primary language
 - Citizenship status
 - Evidence of effectiveness of cultural competency education
 - Diversity of faculty and student body
 - Declining student interest in holistic care
 - Value of cultural competence
 - Equitable access to healthcare services
 - Legal imperatives
 - Economic impact
 - Individual responsibility for racial and ethnic disparities
 - System's impact on racial and ethnic disparities
- 3) Address the following extrinsic educational considerations:
 - Advocacy for cultural competency at local, state and national levels
 - Public support for efforts aimed at establishing cultural competency and increased access to healthcare services
- 4) Conduct educational reform by developing, implementing and evaluating cultural curriculum development, implementation and evaluation. The curriculum must include:
 - Goal-specific cultural instruction
 - Measurable curricular objectives
 - Acceptable levels of cultural competence
 - Evaluate cultural competence skills
- 5) Facilitate cultural competency in all elements of medical education, including:
 - Faculty development
 - Clinical education venue selection and development
- 6) The cultural competency curriculum must be consistent with the institution's educational mission. And, the educational product should respond to public needs, such as:
 - Equity of healthcare access for a diverse population
 - Improved healthcare status
 - Decreased healthcare disparities based on ethnicity
- 7) Facilitate cultural competency by communicating its monetary value and economic impact to the patient, provider, healthcare system and the public.

8) Consider the race factor when addressing healthcare disparities and encourage minorities to enter the medical profession by fostering self-worth.

Overcoming Stereotypical and Biased Thinking

To exemplify racial biases and stereotypical thinking, Dr. Hobbs presented a series of statements and asked participants to determine the race, ethnicity and gender of their sources. He challenged the group to think about how they arrived at their response and informed them that whatever the conclusion, it was based on one's own biases or stereotypes. This exercise indicates that ~ while students, whether of the minority or majority, initially say they do not engage in such thinking ~ all people are prone to biases and stereotypical thinking as a result of life experiences. In order to effectively work in diverse settings, healthcare providers have to cut through these experiences and get down to the facts.

Through a unique relationship with four surrounding counties, for 20 years students at the Medical College of Georgia have worked in healthcare clinics to experience the culturally competent care that exists in these facilities. As a result, that network of community health centers has routinely recruited physicians from the College. This process has created a crop of physicians who are sensitive to cultural competency issues and is a model that could be replicated throughout the state of Georgia.

A Personal Perspective On Fostering Cultural Competence

Raymond Otis, MD

Office of Rural Health Services Advisory Council, Camilla, GA

Dr. Raymond Otis shared his personal experiences surrounding his grandmother not receiving competent care in the small, rural Southwest Georgia town in which he grew up. He also recalled his impressions of the two sets of medical practices that seemed to be used when treating whites and blacks. These experiences motivated him to attend medical school and to work harder in college to achieve knowledge that other students had received in high school. His past experiences, led him to believe that race is still a factor in disparate medical treatment and that there is a need to foster cultural competence through education, recruitment and retention.

He believes that people need only to look at America's history to see the value in having sensitivity to others. After research and examination of the recent reports on health disparities, Dr. Otis has concluded that Georgia needs to ensure that all healthcare providers become more sensitive to issues affecting diverse people in various settings. Robert Wood Johnson Medical School in New Jersey, where Dr. Otis attended, had a 30 percent minority population. There, he was able to associate with people from all areas of the world. He feels that setting helped to foster in him sensitivities to diverse populations, but he is acutely aware that other institutions do not make the same type of efforts to diversify their student population.

Dr. Otis suggested that healthcare providers engage in introspection to determine what issues and prejudices they need to resolve before coming to the patient-care setting. He said, if a patient feels providers take their personal healthcare to heart, they're going to do more to comply with the medical therapies prescribed. The resulting positive feedback also encourages healthcare providers to be more patient-centered and less focused on managed care requirements that leave less time for patient care.

"Our biases are created by our experiences. In order for us to operate in settings, we have to be able to cut through these experiences and get down to the facts and try to work in spite of our biases. We all are victims of this."

*-Joseph Hobbs, MD
Vice Dean, Primary Care
and Community Affairs
Medical College of Georgia*

Race and Ethnicity

Dr. Otis addressed the dynamics of race and ethnicity in healthcare in the context of his personal experiences. There is a growing Hispanic population in Southwest Georgia, and his ability to speak Spanish has benefited him. Presently, he is soliciting to several groups for an interpreter in the region so that healthcare providers can address the issues of its migrant worker population. Another issue facing the small hospital of 12 physicians in which he works, is the negative perception of African-American healthcare providers as being less educated and less qualified to provide adequate care. Although these perceptions are not rooted in fact, they exist nevertheless. He suggests that cross-cultural training be implemented to break through the barriers of negative perceptions.

As a member of the Rural Health Advisory Board, Dr. Otis has become more informed about how he can change on a personal level and what needs to be done on the state level to make Georgia's healthcare system better. Statistical data will not help, he said, if individuals do not act upon the results. He challenged the session attendees to get involved in promoting cultural competence and to become advocates for the proper and effective expenditure of healthcare dollars in Georgia.

As a preceptor for Mercer University, Dr. Otis sees a need for recruiting Hispanic providers and practitioners who are culturally sensitive to a small town that is ethnically diverse. In an effort to foster cultural competence in rural Southwest Georgia diverse group sessions have been held to encourage cross-cultural training, recruitment and retention of practitioners in the area. Dr. Otis' life history suggests that there is an immediate need to recognize Georgia's diverse population and to make available culturally competent healthcare in both urban and rural communities.

Session Recommendations and Additional Considerations

- Several people are responsible for the disparity in healthcare and the challenge of achieving cultural competence is multi-factorial.
- Disparity in healthcare exists even when accessibility is eliminated as a factor.

Grade School Level

- Minority recruitment needs to begin at an earlier age. There should be more aggressive promotion of the medical profession as early as fourth grade, perhaps, and at the undergraduate level.
- More Hispanic practitioners must be recruited at the academic level.
- Medicine has not courted minority males the way the field of engineering has. For example, students are tracked from high school through college. In many cases, students are hired by the corporations that tracked them.
- The Medical School of Georgia goes into high schools and identifies students interested in medical school. These students actually meet medical college admissions officers and administrators. Efforts are underway to get Mercer University to start a similar summer program.
- There is a problem when eighth grade students are required to choose a track. The vocational track inhibits students from considering a career in medicine later down the road.
- One young GRACE participant shared her concern of not being recruited for the medical field earlier in her studies. She was tracked for vocational studies, but opted out. Once she became interested in biology, it was suggested that she get her Masters in Public Health. Previously she was told her grades weren't good enough, but now she is a technician in a medical research lab and is continuing her studies toward her MPH degree.

- Encourage school boards to provide healthcare vocational opportunity programs.
- Encourage summer camps and scholarships for minority campers.
- Educate grade and undergraduate students on medical school requirements, i.e. GPAs, preparatory courses, etc.

Undergraduate Level

- Use real-life culturally competent role models at career fairs.
- Scholarships and service repayment in rural and other areas of need should be used as incentives.
- Provide undergraduate students assistance with applications to medical and dental school.
- Coach and role-play entrance interviews.

Post Graduate Level/Continuing Education

- Medical students do not want the burden of addressing healthcare disparities. It's a lot to "dump" on them in the beginning, because they don't see the benefits.
- We have to associate other values, like economics, to convince students that cultural competence is important.
- Medical students must learn early on that patients who think physicians have their best interest at heart will have a better response to treatment.
- Medical students need to be exposed to effective models. There are too few medical schools that send students to rural settings, and too often these settings are not the best example of a culturally competent clinical environment.
- In good rural clinical environments, four weeks with a physician can empower students to know that they can make a difference.
- There should be more culturally competent mentoring programs.
- There should be more local cross-cultural training experiences, and the opportunity for community service should be emphasized.
- The Medical College of Georgia School of Dentistry has a cross-cultural training program in Dalton – the city with the largest population of Hispanics in Georgia.
- Fewer pen-and-paper measures and more interface models should be used to assess the clinical experience. For example, students should be graded on whether they can get patients through the clinical process.
- The true measure of whether cross-cultural training programs are working is to track their impact on disparity in healthcare.
- There needs to be greater emphasis on a variety of medical professions – science-related fields, clinical and academic, for example.
- The medical profession has erroneously made a decision that only students in the highest of academic standing can get into medical school. This is a service profession that can be done by an average student.
- Provide certification flexibility for international students.

Session I-D: Policy Issues: Should Cultural Competence Be Mandated?

Overview of Standards of Care

James Couch

Chief, Health Improvement Programs, Georgia Department of Community Health

The National Office of Community Health has created Culturally and Linguistically Appropriate Health Care Services (CLAS) standards that have been sanctioned by Congress for states to adopt according to their needs. James Couch, chief of Health Improvement Programs for the GA DCH, summarized the standards in this session and they are listed in entirety here. Healthcare organizations should:

1. Ensure that patients and consumers receive from all staff members effective, understandable and respectful care that is provided in a manner compatible with their cultural health belief and practices and preferred language.
2. Implement strategies to recruit, retain and promote at all levels of the organization a diverse staff, and leadership that are representative of the demographic characteristics of the service area.
3. Ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
4. Provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency (LEP) at all points of contact, in a timely manner during all hours of operation.
5. Provide to patients/consumers in their preferred languages both verbal offers and written notices informing them of their right to receive language assistance services. (DHR and DCH have been challenged by the Federal Office of Civil Rights Compliance to be more responsive to interpretive services needs.)
6. Assure the competence of language assistance provided to LEP patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request).
7. Make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.
8. Develop, implement and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
9. Conduct baseline and ongoing organizational self-assessments of CLAS-related activities and integrate cultural and linguistic competence-related measures into organizational internal audits, performance improvements programs, patient satisfaction assessments and outcomes-based evaluations.
10. Ensure that data on the individual patient's/consumer's race, ethnicity and spoken and written language are collected in health records, integrated into the organization's management information systems and periodically updated.
11. Maintain a current demographic, cultural and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
12. Develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Session I-D

Policy Issues: Should Cultural Competence be Mandated?

Presenters:

James Couch

Chief, Health Improvement Programs, Georgia Department of Community Health

Georgia State Rep. Pamela Stephenson (D-District 60/Post 1)

*Carolina Casares, MPH
Health Policy Analyst, MSM
National Center for Primary Care, Community Voices Program, Atlanta*

13. Ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints by patients/consumers.

14. Regularly make available to the public information about their progress and successful innovations in implementation the CLAS standards and provide public notices in their communities about the availability of this information.

Couch suggested that the conflict in the clinical experience of limited English-speaking patients is not the language barrier itself, but interpretation problems. Specific requirements for providing linguistic services in Georgia need assessment and community and consumer input. There are models of linguistic and cultural competence that are setting good examples for Georgia to follow, such as California. That system's cultural competence contract includes the translation of plan materials to improve access, increased use of community health workers and the use of non-commercial plan surpluses for community education, risk prevention and disease management initiatives. The contract also calls for greater inclusion of minority physicians and traditional providers. It encourages the creation of a market for vendors of services to support cultural competency as well as for bilingual employees in health plans and provider organizations.

As Georgia looks to the future, Couch suggested the State consider a similar approach as California and look beyond medicine to include cultural and spiritual competency as well. He remarked that Georgia should address the conflicts presented by traditional medicines versus alternative medicines as it relates to doctors accepting a patient's desire to incorporate spiritual and natural remedies. This conflict often arises in the Hispanic/Latino as well as the African-American community. We must implement a management plan for patient care, he said, that incorporates non-traditional approaches to healing.

Mandating Cultural Competence

*Georgia State Rep. Pamela Stephenson
D-District 60/Post 1*

Cultural competence begins with individuals and their belief in and endorsement of equal human rights. As we grow as a state, we should begin to see this competence exhibited from our law enforcement officers to our healthcare practitioners. At the core of cultural competence is the fact that our now diverse patient population in Georgia needs to know what their practitioners are talking about as it pertains to their health. The mystique must be taken out of the patient-provider relationship so that patients understand their overall treatment plan during that 15-minute interval that physicians under managed care organizations are charged to spend.

A culturally competent healthcare curriculum should be administered throughout our school system from elementary through college. The curriculum should require certain course work that first fosters patient education. Second, practitioners must learn how to gain a greater understanding and awareness of cultural differences and their own cultural values. They must recognize that people of different cultures have different ways of communicating, behaving, interpreting and problem solving. Practitioners must recognize that cultural beliefs impact a patient's healthcare beliefs.

*"Nothing but good could come out
of the ability to experience and
learn more about other
people's cultures".*

*-Georgia State Rep.
Pamela Stephenson
(D- District 60/Post 1)*

Georgia also must adopt an outcome-focused research agenda. This idea of cultural competence is somewhat a spin-off of medical anthropology when you look at people's beliefs, behaviors and outcomes and line them up against the improvement of the health status of a population. In Georgia, we still, in terms of health status indicators, are comparable to Third World countries. We need only look at life expectancy, infant mortality and morbidity rates among African-Americans as well as the health of African-American males to see the evidence of our poor health status. Even when you correct for economic issues, African-American women are still having premature and immature births. These incidents have a lot to do with the methods in which we practice health care.

As a policy issue, then, how do we bring these issues to the decision makers?

- 1) There should be a requirement for funding providers that involves documentation or evidence that practitioners or organizations have gone through a curriculum and rotation that includes cultural competence training.
- 2) Institutions should be required to show that they have delivered care to indigent patients in a manner that adheres to a community benefit standard – much like the state of Texas model. For example, you cannot be a Medicaid provider of African-Americans if you or no one on your staff has ever completed a cultural competence course and you have no recognition of the differences in their cultural beliefs. At the same time, a provider should not have a population of people with a language barrier that they nor their staff can address because they have not been trained to communicate with them nor to understand their patients' culture.
- 3) Cultural competence training should be a licensure requirement for nurses and mandated through the Department of Human Resources Office of Regulatory Services. We should have a system in place that is standard for all practitioners within our state to follow.

We are now a population of 8 million in Georgia, residing in 159 counties. We have as much of a diverse population as California. Nothing but good could come out of the ability to experience and learn more about other people's cultures. We have the existing CLAS standards. Let's adopt and use them. No more time should be spent studying these standards. Rather, much more time needs to be spent developing consequences of not having culturally competent practitioners and staff who deal with diverse patient populations. We should also spend more time recruiting, retaining and putting people in place who look like the population they serve, which can impact patients in terms of acceptance. Some patients don't even tell you what's wrong, because they fear they will be ridiculed.

In conclusion, we need to do a better job educating consumers and the general population. Then, the regulatory arena should address the practitioners who we send out in private practice and in our healthcare facilities throughout our state to assure that people are respected, treated in a proper manner and accepted. The result will be improved health quality within the state of Georgia.

Enforcing Cultural Competence Laws and Regulations

Carolina Casares, MPH

Health Policy Analyst, MSM National Center for Primary Care, Community Voices,
Atlanta

You can find textbooks on cultural organization that address the issue of changing the way a system operates. You have to look at the issue from two perspectives – individuals and systems. Individuals are born into a household; they grow up in a family. From the day they're born, they have beliefs and basic assumptions. Then they develop attitudes and values. We take these individuals and put them into a system. Everyone has their own way of doing and seeing things and the system incorporates them into a larger culture. This dynamic is the first obstacle that has to be addressed in establishing mandates for cultural competence.

The mandating process begins with communication. We need to talk to the providers and engage them in the process so that they embrace the change and understand the value of the mandate. The mandate should be designed to break down the barriers to increasing the number of minorities admitted to and graduated from medical school.

Session Recommendations

- Laws and mandates are needed to regulate cultural competence in the health profession; however, we have to go beyond law and look at implementation.
- Mandates should be implemented with the same level of aggression that would be used to dismantle any system that delivers unequal treatment. Mandating is designed to address a system in place— that begins with individuals at birth – that creates a disparate outcome in health care.

Cultural incompetence is the result of unequal treatment. You cannot start teaching that in medical school. That is a value system of behavior, conduct and beliefs about the rights of various peoples, such as civil rights. Racial injustice should be addressed early in the higher education process. Otherwise, you've missed something by the time you get to medical school.

- We need to look at mandating and implementing cultural competence as a Constitutional right under the XIV Amendment.
- Mandating creates a ripple effect. Cultural competence becomes incumbent among the practitioner as a standard for credentialing. We have to look at the population of people who are already practicing who are going through continuing education to meet some requirement for the area of specialization. We've got to have that in order to impact the system that drives the provider to spend the time to investigate belief systems as a part of a diagnostic plan with a patient as opposed to imposing standards traditionally.
- The Georgia Board of Medical Examiners licenses all physicians in the state. We have 27,000 licensed physicians. Only 1500 are African American and 1100 are Asian. We have to begin to address these disparate numbers with the recruiting and admissions policies of our medical schools in Georgia.
- We must move beyond the discussion stage and address the 43 percent of pollsters who say our U.S. healthcare system needs change, and the 41 percent who say it needs radical change. We have friends in legislature, and now we have to agitate them so that mandated cultural competence won't be just another law on the books about discrimination.
- The real power is in mobilizing the patients.

- In implementation, Georgia has to ask the question: Is health care a right or a privilege? We assume it's a right because we have put programs in place, but when we have these legislative debates, that question still comes up.
- Implement, hold accountable and then perform the research on how cultural competence mandates work. No profession likes to be policed, but it is the patient and consumer that we should all be concerned about.
- There need to be curriculum changes to include cultural competence coursework in medical school, so that students gain experience treating a diverse patient population.
- Five essential elements must exist in a system before it can become more culturally competent. 1) Value diversity. 2) Have the capacity for cultural self-assessment. 3) Be conscious of the dynamic inherent when cultures interact. 4) Possess institutionalized cultural knowledge. 5) And, develop adaptations to diversity.

"We must address the social structures – institutional racism – the ideology and the passions that sustain a social character that preserves greed and discrimination."

*-Roberto Dansie, PhD
Clinical Psychologist*

Luncheon Address: Rainbow Makers—Healing Across Cultures

Clinical Psychologist Roberto Dansie, PhD, presented a colorful presentation on the healing traditions across cultures, dating back to ancient history. He commented on the symbolism of the acronym GRACE. Grace, he said, is a common element in the healing traditions of the "four corners of the world." In ancient Greece there are three rainbows of grace – wisdom, love and care. With acoustic guitar in hand, he illustrated the role that each plays in the modern world of medicine and invited GRACE participants to reflect on how all three characteristics can contribute to overcoming the health disparities found in society.

Wisdom

Wisdom is more than a way of knowing; it is a way of being. Achieving wisdom, according to Dansie, starts with wonder – amazement at each new discovery in life. It is important that physicians seek not only knowledge – information, but also wisdom – inspiration, which comes from the Latin word "in-spiritus," that is, the power of the Spirit.

Love

Dansie said grace is the essential love that lives in every human being, and he recounted the story of John Newton, composer of the song "Amazing Grace." In 1748, as his slave ship was caught in a potentially deadly storm, Newton opened his heart and realized he could no longer dehumanize himself and his fellow man by continuing in the slave trade. He committed to align his life with the power of love and grace if he survived the storm. The vessel was saved. Newton became a minister and an abolitionist. His song "Amazing Grace" still has the power to heal and two centuries later inspired participants in the Civil Rights Movement. Dansie invited the audience to sing the powerful song.

Care

Dansie suggested that inequality and racism continue to be at the root of health disparities in our society – the unnecessary suffering afflicting people of color, the poor and the oppressed. Greed continues to be the enemy of humanity. Fighting greed is part of the healing process.

Dansie relayed the experiences of the Lakota Indians and how they considered greed to be one of the worst offenses one could commit in their community. The Lakota's anecdote to greed was seeing the world through the eyes of others. This allows people to care for one another and turn away from selfish greed. He said it is not by accident that we find the word "care" right next to the word "health" in our organizations.

Dansie concluded that there is nothing wrong with our health system. It just needs to be turned upside down, with resources going to those who need them the most. To make this happen, the healers must go to the politicians and make them aware of the challenges we face in cultural competency and health disparities.

Session II-A:

Flexibility vs. Uniformity: When do you deviate from standards of care?

While there is no direct evidence that provider biases affect the quality of care for minority patients, research suggests that healthcare providers' diagnostic and treatment decisions, as well as their feelings about patients, are influenced by patients' race or ethnicity, according to the IOM Report, *Unequal Treatment*. Emphasis on diversity and cultural competence challenges health systems to implement standards that are flexible enough to capture the differences within diverse populations without compromising quality. This session explored the necessity of adhering to professional or practice standards of care for cardiovascular disease (CVD) and diabetes versus deviating to account for racial and ethnic diversity.

Benefits of Adherence to Standards of Care

Kathy Berkowitz, RN

Amylin Pharmaceuticals, Marietta, GA

Evidence shows that health plans that deliver the best clinical care also have the "most satisfied" patients. Since satisfied patients are much more likely to follow recommendations being offered, better outcomes are the likely end result. Using the clinical recommendations set forth by the American Diabetes Association and the Healthy People 2010 Objectives, Kathy Berkowitz shared the current standards of care for people with diabetes.

Annually, diabetes patients should have at least one visit with a health professional; a cardiovascular risk assessment; a screening for lipid abnormalities; a foot exam; a dilated eye exam; a dental exam; a screening for microalbuminuria; and an influenza vaccination. Other clinical practice recommendations include a Hemoglobin A1C test twice yearly, if the patient is meeting treatment goals, and quarterly if there's a change in therapy; measure blood pressure each visit; aspirin therapy for all adults, if tolerable; and a pneumonia vaccination. Physicians should also recommend all patients not smoke; provide diabetes self-management education; individualized medical nutrition therapy; physical activity program; promote daily self-monitoring of blood glucose; and evaluate the technique and utilization of blood glucose results

Adherence to these evidence-based standards improve the quality of health care; increase efficiency of healthcare services provided when implemented; reduce overall cost of care or hold cost to a constrained amount of the healthcare dollars spent when used effectively; can prevent improper prescriptive practices; and prevent inappropriate referrals. However, Berkowitz noted that these guiding principles will only enhance overall health care if medical professionals understand and know how to follow them and are willing to integrate guidelines into their delivery of services and if it is feasible to incorporate them into everyday practice.

Acknowledging that clinical practice guidelines have been a part of the healthcare delivery system for two decades, Berkowitz like many others wonders why disparities exist in minority populations. She believes resolutions to this burden of diabetes encompass the self-management education standards. Noting that diabetes is primarily managed by the individual, cultural practices and beliefs have to be taken into consideration. For example, meal plan suggestions and physical activity recommendations should be culturally sensitive and appropriate. The healthcare professional that facilitates the patient's education and training must take the science and translate it to people of different ethnic and minority groups.

Session II-A:

*Flexibility vs. Uniformity:
When do you deviate from
Standards of Care*

Presenters:

Kathy Berkowitz, RN
Amylin Pharmaceuticals,
Marietta, GA

Jade Robinson, RN, MHA,
CCTC
Director, Transplant Services
And Cardiac Wellness,
St. Joseph's Hospital of
Atlanta

Healthcare Professionals as Change Agents

Jade Robinson, RN, MHA, CCTC

Director, Transplant Services and Cardiac Wellness, St. Joseph's Hospital of Atlanta

Noting that the term flexibility implies movement, Jade Robinson made an appeal for all persons in the healthcare community to become change agents. She encouraged providers to commit to enhancing their current knowledge of professional and practice standards through active participation with the American Heart Association and the American College of Cardiovascular Guidelines. She also promoted sharing knowledge and expertise through community outreach activities and forums. More importantly, Robinson advocated that healthcare professionals become involved in the political process and get to know their government officials. Learning to use the power of the vote and building relationships with policy makers can help bring attention to health related issues.

Robinson built a case for political involvement by examining the "Closing the Health Care Gap Act" sponsored by U.S. Senators Bill Frist, MD (R-TN) and Mary Landrieu (D-LA). This comprehensive legislation seeks to reduce and eliminate health disparities for racial and ethnic minorities and other under-served populations. It incorporates the following five principles: 1) expanding access to quality health care; 2) improving national leadership and improving coordination across strategies to reduce and eliminate disparities; 3) increasing the diversity of health professionals and promoting more aggressive health professional education intended to reduce disparities; 4) promoting enhanced research to identify sources of racial and ethnic disparities and assess promising intervention strategies; and 5) improving and expanding programs to prevent, manage and treat diseases and conditions that disproportionately impact minority and under-served populations.

According to Robinson, we need renewed thinking and much work. She feels it is not a question of one or the other. By focusing on uniformity, healthcare professionals are, in essence, ensuring quality is not compromised. By incorporating flexibility, healthcare professionals are acknowledging that they should always deviate according to the patient's needs.

Session Recommendations

- Recruit and train diabetes educators from various cultures, racial and ethnic groups. Patients tend to feel more comfortable with someone who speaks their language versus speaking through an interpreter.
- Increase awareness of the use of culturally appropriate terminology versus simply medical terminology.
- Improve accessibility to resources to which patients are referred.
- Recruit professionals who may have received their training in other countries.
- Identify the cultural gaps in your healthcare systems.
- Develop a network of providers/educators, etc., with varied levels of expertise.
- Evaluate cost to patients.

"The healthcare professional that facilitates the patient's education and training must take the science and translate it to people of different ethnic and minority groups".

-Kathy Berkowitz, RN
Amylin Pharmaceuticals
Marietta, GA

Session II-B: Best Practice Models

Many states have initiated cultural competence initiatives and established offices designated to address specific needs of ethnic populations. A discussion of challenges faced in developing and sustaining such programs and initiatives, as well as significant achievements made will provide guidance in the implementation of similar programs in Georgia. In this session, approaches to eliminating health disparities were shared by representatives from Oregon and South Carolina.

Oregon as a Best Practice Model

Vicky Nakashima

Former Director, Oregon State Office on Multicultural Affairs

Like Georgia, Oregon has one of the fastest growing Hispanic populations. Vicky Nakashima highlighted two best practices, policy initiatives and programs within the state that have had a positive impact on Oregon's health care system:

Oregon's governor was at the forefront in developing a Racial & Ethnic Health Task Force to eliminate health disparities within the state's communities of color. The task force identified four priority areas: access to health care, data collection, workforce development and cultural competency. Oregon's Department of Human Services also adopted a variation of the national standards for culturally and linguistically appropriate services (CLAS). All department programs statewide, including those on the county level, were required to implement these standards. Nakashima noted that considerable effort was required to convince people within the various agencies that the cost would not be significant. It took two years to implement the standards.

With the help of three African-American female legislators, two significant bills were passed. The first statute requires all health licensing boards to collect data on all persons they license by race, ethnicity and language capability. Governor-appointed boards are required to use this data to address disparities in health in under-representation. The subsequent statute requires the Department of Human Services to establish a program for the certification of healthcare interpreters for persons with limited English proficiency (LEP). The latter bill also created a Council on Health Care Interpreters, which is currently establishing the administrative rules and policy standards.

For five years, the public health and medical communities in Oregon have been working with the Mexican government to address the differences in culture, language and health challenges the state's migrant and seasonal farm workers present. The Oregon-Mexico Health Professionals Exchange involves a wide partnership of state agencies, including public and mental health services, practitioners, private sector hospitals and policy makers. The annual alternating exchange program helps professionals from both areas better understand how the other works. According to Nakashima, Mexico has a well-developed health education system, more sophisticated and effective than in the United States. Although childhood immunization rates are higher in Mexico than Oregon, Mexican immunization records aren't generally accepted in Oregon. This results in many unnecessary re-immunizations of children. Work is currently underway to develop a bi-national agreement between Mexico and Oregon.

*Session II-B:
Best Practice Models*

*Presenters:
Vicky Nakashima
Former Director, Oregon
State Office on
Multicultural Affairs*

*Gardenia Ruff, MSW
Director, OMH, S.C. Dept of
Public Health*

“Three traits signify culturally competent organizations. They value diversity, perform assessments and put systems in place that recognize the differences between those providing care and those seeking care.”

*-Gardenia Ruff, MSW
Director, OMH, S.C.
Dept. of Public Health*

Oregon's efforts to recruit a culturally diverse healthcare workforce have resulted in the creation of a new pipeline for nurses. N2K was modeled after the Y2K project, in which state employees were recruited to learn computer programming skills to help avert a crisis. The N2K nursing shortage program targets current bi-lingual/bi-cultural non-professional high-performing hospital employees with an interest and desire to become licensed nurses. Identified by one of five hospitals, these incumbent workers are tested and screened along with their families. Employer partners provide 20 hours paid release time for the selected employees to attend the program. (Grant funds currently cover program costs to release employees identified by migrant clinics and small hospitals. Major hospitals absorb the cost for their personnel.) Program participants retain full-time employment status with their employers while participating in the educational program. After successfully navigating a compressed prerequisite program of study, they are admitted to the nursing program at a community college. All clinical work is performed in their sponsoring hospital. Upon passing the test to become a Licensed Practical Nurse (LPN), employees assume their new position and their rate of pay is adjusted to reflect the change. A two- to four-year employment commitment is required. This employer-sponsored initiative is offered in addition to the current traditional nursing program, which takes a longer time to complete.

South Carolina: A Model Health System for Cultural Competence

Gardenia Ruff, MSW

Director, OMH, S.C. Dept. of Public Health

Gardenia Ruff provided an in-depth look at the evolution of South Carolina's Cultural Competence Initiative beginning with the formulation of a working definition of cultural competence and continuing through the implementation of a statewide strategic plan. From cultural diversity to cultural sensitivity to cultural awareness to cultural appropriateness, Ruff characterized each concept and explained why South Carolina chose to integrate cultural competence – described by Ruff as the broadest prospective, which embraces all the others. The goal was to incorporate culturally competent values, principles, attitudes and policies into all aspects of public care. The Department of Health and Environmental Control (DHEC) worked diligently to shape behavior not change hearts. Ruff described the process as the application of the organization's cultural competence expectations.

Throughout the presentation, Ruff emphasized the need for a systemic approach. From South Carolina's viewpoint, changing systems and making them appropriate and responsive to the needs of diverse populations being served was key. Thus, the state's objective was to institutionalize cultural knowledge by adapting organizations. According to Ruff, three traits signify culturally competent organizations. They 1) value diversity; 2) perform assessments; and 3) put systems in place that recognize the differences between those providing care and those seeking care and manage the resulting dynamics.

South Carolina's response to meeting the language and cultural needs of its increasingly diverse population, eliminating health disparities and complying with legislative and regulatory mandates resulted in a Cultural Competence Action Plan (CAA). CAA provided guidelines for implementing the cultural competence component in DHEC's Strategic Plan. The office also assesses an agency's capacity to address health and environmental issues within the context of culture. This is done through training, workforce diversity, standards/accountability, policies, programs and services. Ruff pointed out that a standard had to be included on every employee's performance evaluation. Written policies and procedures were formulated and incorporated in an administrative manual that was signed off by the commissioner and his executive management team. By creating a system of accountability and establishing measurements for behavior, the state promoted a sense of commitment.

Several outreach efforts that utilized social marketing techniques to reach minority populations were also highlighted. These included: the Real Men Checkin' It Out program, which promotes early detection and screening of prostate cancer; a DHEC/African Methodist Episcopal (AME) Church Partnership, which involves over 600 churches and 200,000 AME members; an Hispanic Health Needs Assessment program that uses lay folk to reach out to undocumented residents; a Five Day Challenge for Better Health, which provides nutritional guidance; and a HBCU/AIDS initiative that hosts an annual summit on the campus of a historically black college or university. The presentation ended with five keys to what Ruff termed "a successful approach" – culturally competent, community-based, community-led, community driven and possessing supportive policies.

Session Recommendations

- Data collection strategies should capture the service area of healthcare professionals.
- Recruitment strategies need to include bridge programs that help foreign trained professionals obtain healthcare jobs in their field of study in the USA.

Session II-C: *Strategies for Working with Culturally Diverse Communities and Clients*

George Rust, MD, MPH.
MSM National Center for Primary Care

B.Waine Kong, PhD
CEO, Association of Black Cardiologists

The IOM report calls for an assessment of the extent of racial and ethnic differences in health care and an evaluation of potential sources of these racial and ethnic disparities. In this session, a series of videotaped vignettes were shown to illustrate the importance of cultural competence. Drs. Kong and Rust engaged participants in dialogue and invited responses after each vignette.

According to Dr. Kong, physicians are oftentimes in denial and do not believe they are biased. Therefore, new and creative strategies on how to deliver cultural competence training had to be devised. Instead of conducting lectures, which have traditionally not been well attended or received, a series of videotaped vignettes are being used to raise awareness and consciousness. Attendees are asked to analyze what occurs in the vignettes as it relates to cultural competence after viewing the skits. Thus, the vignettes serve as a teaching tool to show subtle differences in the response to treatment, unmask healthcare barriers and expose bias during the clinical encounter.

The vignettes dealt with topics such as respect (the number one issue with regards to cultural competence), personal space, communication and foreign customs. The discussions on how each situation could have been improved that ensued among GRACE participants clearly demonstrated the effectiveness of this type of training.

In response to the vignette on respect, participants pointed out the ways in which the physician showed a lack of respect for the patient, such as addressing a senior African-American woman with the expression "that a girl." Participants suggested ways that physicians can be more respectful by methods such as apologizing once a patient has been offended; not invading a patient's personal space by advancing without permission; by giving the patient time to discuss his/her concerns; and by listening intently to the patient, giving the patient his/her full attention. Participants also suggested that physicians should be aware of certain behaviors that are respectful in some cultures, but disrespectful in others.

Session II-C
*Strategies for Working with
Culturally Diverse
Communities And Clients*

Presenters:
B.Waine Kong, PhD
CEO, Association of Black
Cardiologists

George Rust, MD, MPH
MSM National Center for
Primary Care

After the vignette “Speaking My Language,” participants discussed the adverse reactions that can occur when minority healthcare professionals speak languages other than English in mixed company. They suggested that a follow-up explanation in English of what was being discussed could help ease the tension. Others suggested that only English should be spoken by healthcare professionals in mixed company to avoid offending anyone. Additional training was suggested as a means for safely navigating around the language issue.

The vignette on cultural differences between doctor and patient led to a discussion on ways to better care for patients who are of a different culture. Dr. Kong suggested that understanding early on the dos and don'ts of approaching people of varying ethnicities and cultures could improve the patient-doctor relationship and, ultimately, care. Dr. Rust asserted that if a line must be drawn and the patient's needs cannot be accommodated, healthcare professionals should learn to draw the line in a respectful manner.

The final vignette drove home the idea that culture is defined in individual terms not in generalizations, as demonstrated when an Indian woman makes physical contact in a friendly conversation with a physician. This action was in contrast to the previous vignette in which a husband refused to let a male doctor deliver his wife's baby.

Participants discussed the complexity of cultural competence and the need for training as well as the individual professional's need to increase his/her own awareness of other cultures. Through personal stories, Dr. Rust also shared the benefits of getting to know the community through home visits; asking patients what is an appropriate greeting; learning language that shows respect; using communication that is inclusive and being patient-centered. He noted that culture does not define who we are, but is a part of whom we are and is expressed through individuals over time.

Georgia is one of five states in the southeast that make up what is known as the Stroke Belt. These states have unusually high rates of morbidity and mortality due to stroke and other heart diseases. Cardiovascular disease is the leading cause of death in Georgia. There is also a significant link between diabetes and cardiovascular disease. To adequately address these health concerns for its minority populations, Georgia's health systems must incorporate interventions that promote culturally appropriate lifestyles and behavioral changes.

Session II-D: Promoting Culturally Appropriate Lifestyles to Prevent CVD and Diabetes

Bridging the Treatment Gap

Neil F. Gordon, MD, PhD

Medical Director, Center for Heart Disease Prevention, St. Joseph's/Candler Health System, Savannah, GA

The challenge – bridging the treatment gap between the care patients are receiving and reality – was set forth by Dr. Neil Gordon. His presentation gave an overview of comprehensive scientifically based lifestyle management and chronic disease risk-reduction programs developed in Savannah and currently being implemented in the United States, Canada and South Africa. Working with both healthcare systems and leading academic institutions, Dr. Gordon is attempting to move beyond awareness and education to an intervention approach that helps people make changes. He has incorporated a lot of what is known about lifestyle management and behavior modifications into a sophisticated computerized participant management, tracking, reporting and outcome system that guides the patients and program staff. Although cardiovascular disease is the primary focus, diabetes and other preventable conditions are also being targeted.

Acknowledging that it is hard to get people to make and adhere to meaningful lifestyle changes, Dr. Gordon provides two types of programs. The one-on-one counseling program is administered entirely by non-physician healthcare professionals such as nurses, dietitians, and exercise physiologists that may be providing other services to the patient. Thus, the program is designed so that a single professional can provide all aspects of counseling. Counseling is facilitated either face-to-face or via the telephone.

The self-help program, which does not comprise counseling, is individualized for each participant. Like the former program, the self-help program can include multiple delivery mechanisms. Both programs can also be managed over the Internet if the patient has Internet access. Dr. Gordon highlighted the availability of high-touch and high-tech components. Key components of the programs are the:

1. use of health risk appraisals to identify potential participants;
2. detailed health information that comprises the baseline data collected when patients enroll into a program;
3. patient progress reports, physician updates and group outcome reports automatically generated by the system;
4. action plans that are mapped out to help patients achieve their goals; and
5. database, which results from the patient data that is used to conduct research and randomize clinical trials.

Both program types are integrated with the participants' regular medical care. A patient can have a comprehensive program or an individualized program that focuses on single behaviors such as weight management, nutrition, exercise, self-care activities, and smoking-cessation and stress management. Healthcare professionals facilitating the program help patients implement their action plan one step at a time. Although the system maps out the action plan, the healthcare professional or physician can override the computer's recommendations. Generally, this is done to accommodate a patient's personal preference and/or stage of readiness. Dr. Gordon stated that he tried to make the programs culturally appropriate, but more work is needed. Thus, cultural barriers might also be a factor as to why the action plan is modified.

Reports are generated for both the participants and physicians. The participant progress reports show each risk factor, current values, goals – based on national guidelines and an action plan to achieve goals. Similar data is included on the physician report, which has been incorporated in the programs to ensure that a patient's physician is kept in the loop. Dr. Gordon noted that patients are referred back to their physician for follow-up evaluations. The innovative program's clinical effectiveness – which shows that many patients with classic CVD risk factors can achieve risk reduction goals by initiating lifestyle changes – has been well documented in scientific manuscripts and has been replicated in other studies Dr. Gordon has conducted. However, he concedes that it is much easier for physicians to prescribe medication and that, unlike medication, lifestyle management is currently not reimbursable under Medicare.

*Session II-D:
Promoting Culturally
Appropriate
Lifestyles to Prevent CVD
And Diabetes*

Presenters:

*Neil F. Gordon, MD, PhD
Medical Director, Center for
Heart Disease Prevention, St.
Joseph's/Candler Health System,
Savannah, GA*

*Priscilla Johnson, PhD
Morehouse School of Medicine,
Preventive Research Center,
Atlanta*

*Fleda Mask Jackson, PhD
Visiting Associate./Principle
Investigator, Centers for Disease
Control and Prevention, Atlanta*

Meeting Patients Where They Are

Priscilla Johnson, PhD

Morehouse School of Medicine, Preventive Research Center, Atlanta

Dr. Priscilla Johnson emphasized that health organizations and practitioners need to be culturally aware of their client's circumstances and meet them where they are to prevent them from giving up. Being culturally competent means knowing what an individual values and what he/she sees as important. If practitioners take into consideration whom they are talking to when discussing lifestyle changes, it may be determined that other prevention strategies are appropriate. This knowledge also can be used to develop better educational programs, which Dr. Johnson believes need to address the "why" questions and include visuals that communicate solutions in the patient's realm. Dr. Johnson also pointed out that getting buy-in from the top is critical to implementing lifestyle changes. Using the American Heart Association's faith-based health initiative "Search Your Heart," which targets the risk factors for heart disease and stroke as an example, she underscored how effectively churches can influence those in African-American communities. The goal as Dr. Johnson sees it is to empower individuals to take responsibility for their own health.

How Race and Gender Impact Health

Fleda Mask Jackson, PhD

Visiting Associate/Principal Investigator, Centers for Disease Control and Prevention, Atlanta

Invoking the theme "Where Do Broken Hearts Come From," Dr. Fleda Jackson used her research on disparities in the reproductive outcomes among African-American women to illustrate how race and gender can impact health. This community-based study which was conducted in Atlanta and included 600 women between 17 and 77 years of age, sought to identify the stressors confronted by African-American women that are embedded in their personal experiences. Using focus groups, a robust methodology and validity testing, Dr. Jackson's research found an association between poor health outcomes and the racism and gender oppression confronting African-American women. Employed throughout her various research projects, Dr. Jackson stated that cultural competence involves understanding an individual's culture and the community. She also noted that marketing strategies should not be based on assumptions, but need to relay personal messages. In closing, Dr. Jackson expressed her desire for comprehensive services inclusive of mental health providers.

Session Recommendations

- Cultural competence training must start with residents. It just may be too late to teach it to those who have been practicing for many years.
- With good history taking and some conversation, physicians can learn to better relate to their patients and become more knowledgeable about how to effectively establish lifestyle changes.
- With conferences like GRACE, that foster awareness among people in the community, patients can become empowered to make their physicians more culturally competent, because sometimes they're concentrating on the lab work, on who's next or personnel shortages, not the patient.
- We have to teach patients to take responsibility for their own health and to ask questions.
- We have to market good health better from a cultural competence perspective, at the place where people live. It is still too clinical and based on numbers, charts and statistics that patients don't feel refer to them personally. And, if it does refer to the patient personally, marketing must address the real and specific cost to their lives.

- At the foundation of most cultures, is a spiritual precedence for what foods the body should consume. This is one perspective from which providers can attempt to reach their patients and encourage a lifestyle change.
- Physicians should resist the urge to address acute problems – due to their busy work environments – and focus more on prevention.
- Indigent patients benefit greatly from risk reduction programs. More focus should be placed on such programs in addition to treating impairments caused by risky behavior, such as stroke, diabetes and CVD.

Closing Plenary: Where Do We Go From Here?

Grady Health System is the largest public hospital-based health system in the Southeast and is the centerpiece of the safety net for the healthcare system in Georgia and the Southeast region. To help chart the course for where healthcare providers, advocates and stakeholders in Georgia go from here, President and CEO of Grady Health System, Dr. Andrew Agwunobi, shared Grady's role in addressing cultural competence and health disparities. The core goals of Grady are to create a culturally competent environment for African-Americans, Latinos, Asians, other minorities and children seeking care at the hospital and its community systems; to provide access, both financial and geographic; and to provide equitable care that's focused on the most critical areas of health disparities.

Dr. Agwunobi tapped Dr. Otis Brawley, professor of Medicine, Oncology and Epidemiology at Emory University in Atlanta, to present the keynote address for the GRACE symposium's closing plenary. Brawley also is Grady's Medical Director of the Georgia Cancer Center for Excellence.

Where Do We Go From Here?

Otis Brawley, MD

Professor of Medicine, Oncology and Epidemiology, Emory University/Medical Director, Georgia Cancer Center for Excellence, Atlanta

According to Dr. Brawley, to make programs designed to reduce health disparities effective, we must address cost and quality of care for everyone. Poor people often get poorer quality care. There are 35 million Americans who are poor in the United States and 44 million who are uninsured. We live in a time when 25 percent of the poor in America are represented in only 12 percent of the population and 15 percent of them are uninsured. Among African-Americans, 24 percent are poor. Among Hispanics, 22 percent are considered poor. And 8 percent of the white population in America is poor. However, poor white Americans can be looked upon as the invisible minority or special population in this country. The statistics on the uninsured show that 20 percent of African-Americans and 32 percent of Hispanics are uninsured in the United States.

These statistics raise the question, "How are we going to pay for care when we currently stress spending large amounts of money on people when they get very sick, and very little money on preventative services like education?" We must begin to teach people healthful habits when they are in the fifth and sixth grades, not when they are 50 and 60 years old. We have to realize that resources are scarce, so we need to use them as wisely as possible. We have to stress cultural competence for our healthcare providers and at the same time continue to stress self-responsibility on the part of the patient. We also need to increase the numbers of minority populations represented among medical professionals. There are fewer assistance programs today than there were 20 years ago, and that trend must be reversed if access to medical education is to improve for this and future generations.

*Closing Plenary:
Where Do We Go From Here?*

Presenters:

*Andrew Agwunobi, MD, MBA
President/CEO, Grady
Health Systems, Atlanta*

*Otis Brawley, MD
Professor of Medicine, Oncology
An epidemiology,
Emory University/Medical
Director, Georgia Cancer
Center for Excellence, Atlanta*

*James Couch
Chief, Health Improvement
Programs, Georgia Department
of Community Health Atlanta*

There needs to be a media push to publicize and personalize the problem of health disparities as hospitals are beginning to go bankrupt across the nation. The politicians in the late 80s and early 90s tried to say that disparities exist because of genetic inferiority. Scientific studies show, conversely, that equal treatment yields equal outcomes, and the problem in America is that there's not equal treatment. Race is not a biological entity, but a socio-economic factor in a disparate healthcare system. Cancer research, for example, exhibits the disparities in mortality rates between African-American and white Americans, with blacks having far worse outcomes. Although the statistics are not as great, the statistics we do have show that blacks in the Southeastern United States have worse mortality rates than those in other parts of America.

There are cultural differences in the acceptance of therapy. Sometimes physicians have to accept those differences. There also are disparities in co-morbid disease, especially in cardiovascular disease, obesity, hypertension and diabetes that make it harder to treat many cancer patients. This dynamic leads to the conclusion that there must be a focus on overall health rather than on cardiovascular disease or cancer separately.

Access to therapy and access to care is a huge issue. Racism and socio-economic discrimination is also very important. The most important question that researchers in this area of disparity and cultural competence can devote to is discovering how we can provide adequate and high quality care to a population that so often has not received any. Resources are incredibly scarce and we have to use them wisely. For example, it is unpopular to acknowledge the fact that prostate cancer screenings for African-American males have not been proven to save lives; on the other hand, colon cancer screenings have. There is a lot of money to be made from prostate cancer screenings, but three separate scientific studies have proven the effectiveness of colon cancer screenings. This suggests that those monies could be used more appropriately, and we must not be afraid – if we are interested in minority health – to push for better use of funds and walk away from the urge to make money.

Science and medicine is ever evolving. There will always be uncertainty, but that uncertainty must not confuse people and deter them from coming to the table. We should welcome the shift in focus from fixing health problems to preventing them. Physicians must talk to their patients and rebuff the notion of seeing 4.1 patients in one hour. That is not enough time to counsel a patient on preventative care and ways to improve their health status. Practicing preventive medicine and giving high quality care can work; this needs to be stressed and publicized. We have to try to make sure that Americans hear the “splash” – that they are informed of the magnitude of the health disparities in our country.

Session Recommendations

- Pharmacies are a good place for sharing health information. Pharmacists often are the first or only point of contact beyond the medical examination. They should be empowered and utilized more as guides to preventive health measures as well as guides through the health system.
- We should encourage more initiatives like that of Atlanta's Channel 46-TV and CVS who teamed up to distribute strips for detecting blood in bowel, an indicator of colon cancer. Recipients were encouraged to see a doctor if blood was present.
- Grady has placed neighborhood health centers in areas like Center Hill in Northwest Atlanta, which has some of the worse health outcomes in the region, in an effort to bring preventive healthcare information to people in low-income areas.
- Other places, like Puerto Rico, have placed information stands in the produce sections of supermarkets to promote healthy eating habits. It is suggested that Georgia should do the same.

- The media and schools should encourage parents to introduce healthy diets to children to combat the trend of the introduction of unhealthy foods that can lead to heart attacks.
- Full health insurance will not fix the problem of health disparities — given that even in countries with good health systems disparities still exist — but it would make the situation far better.
- We must guard against cultural competency becoming an excuse or over stressed, given that African-Americans, for example, tend to be fatalistic about their own health. Attention must be given to this tremendous barrier as well.

Closing Remarks

James Couch

Chief, Health Improvement Programs, Georgia Department of Community Health

We are embarking upon a journey where there will be no easy answers. It is important for us to be willing to grasp the complexity of health disparities. We're all coming to this topic from a particular lens, yet our challenge is to hold the reality that health disparities have racial and cultural dimension, and that there is an even deeper socio-economic dimension to it. Health activism toward equity in health care will play a critical role.

Community residents must be equally empowered to have a more clear and informed voice about their health and healthcare experiences. Nurses, doctors, frontline staff and all health professionals must be invited to commit to the effort. The work has already begun. One best practice model is the West End Medical Center. Its bilingual-bicultural services program for Sub-Saharan African populations has resulted in about 200 births at the Center to date. Our goal is to replicate this kind of success in areas of health care in Georgia where disparities exist.

The Georgia OMH's three-year strategic plan will provide a special opportunity for the health community to address health disparities. The Office of Minority Health and its Advisory Council will be responsible for rolling out the strategic plan. As the plan unfolds OMH will call upon the existing resources of organizations such as the Georgia Board for Physician Workforce and the State Medical Education Board. Grady Health System will be called upon to lead the effort to combat cultural disparity in terms of health delivery. Medical, nursing and other institutions focused on health care in Georgia will be asked to develop the clinical research methods and practices needed to address health disparities and cultural competence. This multi-dimensional strategic approach to disparate health care and cultural competence should reap unprecedented results in the health status of Georgia's minority populations.

Note: All presentations, commentary, dialogue and session recommendations from GRACE are the expressed professional opinions of the participants based on their experiences in their perspective fields. GRACE participants completed commitment cards pledging to work in a sustainable way against health disparities in their communities and were asked to share the commitment forms with those stakeholders who were not represented at the symposium. A directed and concerted effort will be utilized over the next three years to develop and implement Georgia's strategic plan to address health disparities. All presentations, commentary, dialogue and session recommendations from GRACE will be used as a guide in this development process. The strategic plan can only be successful with the continued input, support and commitment of all healthcare professionals, advocates and stakeholders in Georgia. PowerPoint presentations and supporting documentation from the GRACE Symposium can be obtained upon request from the Office of Minority Health and can be viewed at www.state.ga. A limited number of printed copies of the Summary of GRACE proceedings also are available through the OMH.

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